FOR ARGUMENT

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In the Supreme Court of the United States

OCTOBER TERM, 1978

No. 78-223

NATIONAL LABOR RELATIONS BOARD,
Petitioner,

vs.

BAPTIST HOSPITAL, INC.,
Respondent.

BRIEF OF HOSPITAL CORPORATION OF AMERICA AS AMICUS CURIAE IN SUPPORT OF RESPONDENT, BAPTIST HOSPITAL, INC.

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INTEREST OF AMICUS CURIAE

HOSPITAL CORPORATION OF AMERICA (hereinafter HCA) is the parent corporation or manager of approximately one hundred twenty-three hospitals which operate across the United States. HCA hospitals have a capacity of over 18,000 beds and employ approximately 37,000 employees. The Court's decision in the above case is of major concern to HCA because of the impact the decision

could have on tailoring no-solicitation/distribution rules to the special circumstances presented by a hospital setting.

HCA participated as *amicus* in *St. John's Hospital and School of Nursing, Inc.*, 557 F.2d 1368 (10th Cir. 1977), in the Petition for Writ of Certiorari in *Lutheran Hospital of Milwaukee, Inc.* v. *NLRB*, 435 U.S. 941 (1978), and in the case *sub judice* in the Sixth Circuit Court of Appeals. *NLRB* v. *Baptist Hospital, Inc.*, 576 F.2d 107 (6th Cir. 1978). HCA is presently participating as *amicus curiae* before the National Labor Relations Board in three cases which share the common issue of the validity of no-solicitation/distribution rules in hospitals.[1]

HCA has received permission from both the Respondent and Petitioner to participate in this case.

INTRODUCTION

Decisions subsequent to this Court's decision in *Beth Israel Hospital* v. *NLRB*[2] have been confused and conflicting in their application of *Beth Israel's* holding. This confusion necessitates a reexamination of the underlying principles in that case.

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1. The three cases are *Lutheran Hospital of Milwaukee, Inc.*, Case No. 30-CA-3082, *Baptist Memorial Hospital*, Case No. 26-CA-5921 and *Beth Israel Hospital*, Case No. 1-CA-11469. *Lutheran Hospital* is the same case remanded by this Court on June 26, 1978 in *Lutheran Hospital of Milwaukee, Inc.* v. *NLRB*, 435 U.S. 941 (1978). *Beth Israel* is a separate case from the one decided by this Court in *Beth Israel Hospital* v. *NLRB*, ... U.S. ....., 57 L.Ed.2d 370 (1978), but it involves the same hospital. The issue in this second case involves the validity of the hospital's no-solicitation rule as it applies to areas of the hospital other than the cafeteria.

2. ..... U.S. ....., 57 L.Ed.2d 370 (1978).

Background

On March 4, 1976, the Board issued its *St. John's*[3] decision. The decision was a reversal of the Board's prior position as to the validity of hospital no-solicitation/distribution rules.[4] It held that no-solicitation/distribution rules in areas to which patients and visitors have access, other than immediate patient care areas, are presumptively unlawful.

The application of this presumption resulted in a multitude of contested Board decisions and conflicting circuit court holdings. [*See, Baylor University Medical Center, Inc.* v. *NLRB*, 578 F.2d 351 (D.C. Cir. 1978) (*enf. denied* in part); *NLRB* v. *Baptist Hospital*, 576 F.2d 107 (6th Cir. 1978) (*enf. denied*); *St. John's Hospital and School of Nursing, Inc.* v. *NLRB*, 557 F.2d 1368 (10th Cir. 1977) (*enf. denied*).] Each circuit court seemed to apply the general rule in a new way. Several courts refused enforcement altogether.

On June 22, 1978, this Court's *Beth Israel*[5] decision was handed down. In a bare five man majority, this Court held "that the Board's general approach of requiring health-care facilities to permit employee solicitation and distribution during nonworking time in nonworking areas, where the facility has not justified the prohibitions as necessary to avoid disruption of health care operations or disturbance of patients, is consistent with the [National Labor Relations Act]."[6]

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3. *St. John's Hospital and School of Nursing, Inc.*, 222 NLRB 1150 (1976).

4. *See, Guyan-Valley Hospital, Inc.*, 198 NLRB 107 (1972).

5. *Beth Israel Hospital, supra* n. 2.

6. *Id.* at 389.

The balance of this Court's *Beth Israel* decision was limited to the facts of the case.[7] It did not approve application of the Board's general rule as it may relate to employer rules banning solicitation or distribution in other "nonwork areas" (besides employee dominated cafeterias) of the hospital.[8] Further, it did not adopt the Board's "immediate patient care area" terminology for defining what constitutes "working areas,"[9] undoubtedly due to the inherently undefinable nature of that term.

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7. The facts of *Beth Israel* were horribly one-sided. The area of the hospital in which the no-solicitation/distribution rule was applied was a *de facto* employee-only cafeteria. This is not the typical patron composition of most hospital cafeterias.

8. The limited application of the majority's opinion was noted by Justice Powell in footnote nine to his concurring opinion. "[T]he Court's opinion expresses no view as to the validity of prohibiting employee solicitation or distribution in other areas of a hospital which may not be devoted 'strictly' or 'immediately' to patient care but to which patients and visitors have access. The question was not presented in this case." *Beth Israel Hospital* v. *NLRB*, *supra* n. 1, 57 L.Ed.2d at 396 n. 9.

9. "Work area", or similar terms, as used here and elsewhere in this brief and as used by this Court in its *Beth Israel* decision, refers to the areas of a hospital which are used to administer patient care and therapy. Obviously, work is performed in other areas of the hospital which are not utilized in the delivery of medical care, e.g., laundry rooms.

The traditional *Republic Aviation* analysis applies to work areas of a hospital which are not involved in the delivery of patient care, e.g. employees may lawfully be prevented from engaging in solicitation or distribution in work areas on working time.

This consideration was overlooked by the Tenth Circuit in *St. John's Hospital and School of Nursing, Inc.* v. *NLRB*, 557 F.2d 1368 (1977). In *St. John's*, part of the Tenth Circuit's decision found "substantial evidence" in the record as a whole to support the Board's finding that the hospital had committed an unfair labor practice by reprimanding employees for engaging in prounion discussion in a supply room while on working time. The Tenth Circuit's holding was undoubtedly a product of its preoccupation with defining the scope of legal no-solicitation/distribution rules as applied to patient-care areas of the hospital.

Regardless of the Tenth Circuit's *St. John's* decision, it cannot be candidly argued that an employer may not restrict its employees from engaging in solicitation or distribution while on working time.

On October 30, 1978, this Court affirmed that portion of *NLRB* v. *Baylor University Medical Center*[10] dealing with the validity of a no-solicitation/distribution rule in the hospital's corridors. The 6-3 decision specifically noted that the corridor issue was "neither involved nor considered by the Court in *Beth Israel*."[11]

On January 8, 1979, this Court granted the National Labor Relations Board's Petition for Writ of Certiorari in the case *sub judice*. Unlike *Beth Israel*, this case involves the hospital-wide application of a contested no-solicitation/distribution rule. Unlike *Beth Israel*, this case contains record evidence of other areas in and around the hospital in which organizational rights can be effectively exercised. Most importantly, unlike *Beth Israel*, this case contains record evidence of uncontradicted testimony from the hospital's medical staff that maintenance of the hospital's no-solicitation/distribution rule is necessary to insure the proper delivery of patient care.

HCA anticipates that this Court is preparing to issue a definitive decision regarding the validity of no-solicitation/distribution rules in all areas of the hospital. HCA urges this Court to remedy the narrow and illogical application that the Board has given its general approach to defining "work areas" of a hospital. Alternatively, HCA urges this Court to reconsider its *Beth Israel* decision and reject the Board's general approach altogether.

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10. ..... U.S. ....., 58 L.Ed.2d 202 (1978).

11. *Id.* at 204. Justice Brennan's dissenting opinion took the view that the circuit court's opinion in *Baylor* was in direct conflict with this Court's *Beth Israel* decision. *Id.* at 205.

ARGUMENT

I. The Board's Lay Conception of "Work Area" Is Unworkably Narrow

In *St. John's Hospital and School of Nursing, Inc.*[12] the National Labor Relations Board ostensibly recognized that the special needs of a hospital justify no-solicitation/distribution rules in areas of the hospital in which patients receive medical care. The Board then proceeded to contradict itself by noting only the narrowest and most obvious areas of a hospital as those in which no-solicitation/distribution rules would be appropriate. "[A] hospital may be warranted in prohibiting solicitation even on nonworking time in strictly patient care areas, such as patients' rooms, operating rooms, and places where patients receive treatment, such as x-ray and therapy areas."[13] This lay approach to defining "work area" has resulted in conflicting Board and court decisions illustrating the unworkability of the narrow definition.

The Board's *St. John's* decision proceeded no further than the initial appeal to the Tenth Circuit before the unworkability of the new[14] general approach became evident.[15] Chief Judge Lewis specifically noted in his opinion the inconsistent results which would obtain from application of the Board's confused approach.

12. 222 NLRB 1150 (1976).

13. *Id.*

14. This new general approach resulted from the Board's reversal of its prior position which was adopted in *Guyan-Valley Hospital, Inc.*, 198 NLRB 107 (1972).

15. *St. John's Hospital and School of Nursing, Inc.* v. *NLRB*, 557 F.2d 1368 (10th Cir. 1977).

> It is unclear from the Board's decision what restrictions would be allowed in other areas accessible to patients but not specifically classified by example such as hallways, elevators, stairs, or waiting rooms. The only guideline for classifying these areas supplied by the Board's decision is the blanket assertion that [o]n balance, the interests of patients well enough to frequent such areas [as cafeterias, lounges, and the like] do not outweigh those of the employees to discuss or solicit union representation. A.R. at 35. Under this rationale the distinction between various patient access areas is made to turn on the condition of the patients 'frequenting' these areas and whether such areas are 'strictly' devoted to patient care.
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> We are therefore compelled to conclude that the ultimate factual inferences on which the Board's distinction was based were drawn not from the record evidence but rather from the Board's own perceptions of modern hospital care and the physical, mental, and emotional conditions of hospital patients—areas outside the Board's acknowledged field of expertise in labor/management relations. Moreover, this distinction is difficult of application at best and indeed has been rejected by the Board in a similar context as 'specious'.[16]

The United States Circuit Court for the District of Columbia also concluded that the Board's general approach was impossible to apply.[17] In *Baylor University Medical Center* v. *NLRB*,[18] the court refused enforcement of that

16. *Id.* at 1372-73.

17. *Baylor University Medical Center* v. *NLRB*, 578 F.2d 351 (D.C. Cir. 1978).

18. *Id.*

part of the Board's order which prohibited the hospital from enforcing a no-solicitation/distribution rule in the hospital's corridors. The Board had reached the untenable conclusion that Baylor University Medical Center's corridors, which serve as passageways through which thousands of ambulatory patients pass each day, which serve as the only avenue for delivering life-sustaining medical aid which must be ready at a moment's notice and which occasionally serve as an area in which emergency aid is administered, are not involved in the delivery of immediate patient care.

> We agree with the Tenth Circuit that even were it possible—which it manifestly is not—to determine with any confidence and rationality which areas in a hospital are and which areas are not 'immediately' involved in patient care, the Board's overly restrictive position on the valid extent of no-solicitation rules in medical facilities must nevertheless be overturned as insensitive both to the unique conditions found in an acute general hospital and to the declared intent of Congress.[19]

And even though the Seventh Circuit in *Lutheran Hospital of Milwaukee, Inc.* v. *NLRB*[20] purported to have no problem in applying the Board's new rule, that same case has subsequently found itself before this Court,[21] before the Seventh Circuit[22] for a second time and, finally, before the Board[23] for reevaluation.

This muddled situation mandates a more realistic application by the Board of its general approach.

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19. *Id.* at 353.
20. 564 F.2d 208 (7th Cir. 1977).
21. 435 U.S. 941 (1978).
22. No. 78-1668, Sept. 28, 1978.
23. *Supra* n. 1.

II. "Work Area" Must Be Broadly Defined to Include (1) the Areas of a Hospital in Which Patients Receive Their Therapy and Care, (2) the Areas Which Are Vital to Servicing of Areas in Which Patients Receive Therapy and Care, and (3) the Areas Which Are in Close Proximity to Areas in Which Patients Receive Therapy and Care.

In determining what areas of the hospital are "work areas" for the purpose of applying its presumption to rules on solicitation, the Board should include not only areas of a hospital which are vital to the servicing of the patient care areas, but also areas of a hospital which are in such close proximity to patient care areas that solicitation or distribution in those areas would invoke the same concerns as would solicitation or distribution in the actual areas of the hospital reserved for patient care and therapy.

A prime example of areas of the hospital which are vital in servicing those areas of the hospital reserved for patient care and therapy are hospital corridors.[24] Corridors are critical to a hospital. Depending on the treatment and the particular hospital, corridors may also be used as an area for patient care and therapy, particularly for ambulatory patients.

> "The importance of preventing crowding and disruption in the hospital corridors cannot be seriously debated. Quick and unimpeded passage through the hallways was shown to be imperative to the efficient operation of the hospital and to the success of certain of its emergency services, such as the cardiac arrest unit. The hallways serve not only as passageways for pa-

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24. The term "corridors" should be broadly defined to include any areas of the hospital through which medical personnel and equipment traverse. For example, hospital stairwells are continually used by medical personnel to go floor-to-floor for each succeeding medical emergency.

tients, visitors, doctors and medicine, but also as viewing rooms for the nursery and storerooms for a variety of hospital equipment which must be available at a moment's notice."[25]

In addition, in many hospitals, especially general city or county facilities, therapeutic aid and other patient care is necessarily administered on a regular basis in the hospital corridors due to constant overcrowded emergency and admitting room areas. This is especially so in large urban areas.

An example of an area of a hospital which is in close proximity to patient care areas might be a kitchen in which only hospital employees are allowed, but which is in such close proximity to the patient-only dining area for patients with emotional or nervous disorders that the patients could overhear or observe solicitation and distribution efforts. Another example might be a nurses station which is located so close to patients' rooms that patients could see or hear pro or anti-union solicitation.

Therefore, before applying the general approach approved in *Beth Israel* on an industry-wide basis, the Board should broadly define "work area" as including (1) the areas of a hospital in which patients receive their therapy and care, (2) the areas of a hospital which are vital to the servicing of areas in which patients receive their therapy and care, and (3) the areas of a hospital which are in such close proximity to the areas in which patients receive therapy and care that patients in those latter areas can see or overhear the solicitation activity.

Even though broadly construed, a different definition of "work area" will necessarily result for each case due to

25. *Baylor University Medical Center, Inc.* v. *NLRB, supra* n. 16, 578 F.2d at 355.

varying situations. As argued immediately *infra*, accurate definitions of "work area" in each case can only be obtained pursuant to individual, case-by-case evaluation.

III. The Board's General Approach Is Workable Only If Applied on a Case-by-Case Basis After Considering Testimony From the Hospital's Medical Staff.

In *Beth Israel* this court did not adopt the Board's "strictly patient care area" definition of "work area," as that term was defined by the Board in *St. John's*.[26] As cases subsequent to *St. John's* have clearly demonstrated, the term "strictly patient care area" is a nebulous and amorphous term which has different meanings in different situations. It cannot be applied to all hospitals in general because of the tremendous variation in types of hospitals, species of illnesses and methodology of therapies.[27]

The examples of "patient care" areas given in *St. John's*[28] are too limited. It is an unrealistic application of the term "patient care" to limit the areas in which patients receive care and therapy to only those areas of the hospital which laymen traditionally consider treatment areas. The Board simply cannot convert laymen ideas as to what areas of a hospital are to be considered "strictly patient

26. 22 NLRB 1150.

27. To attempt to classify all the potential therapies for all the various illnesses would be an impossible task even for a physician. The very fact that physicians adopt specialties is evidence of the incredible multiude of potential therapies that medical science has developed to combat the equally staggering number of patient sufferings. This complex situation is made even more difficult of broad classification when the different types of hospitals specializing in administering new and unique types of therapies is taken into consideration.

28. *I.e.*, "patients' rooms, operating rooms, and places where patients receive treatment, such as X-ray and therapy areas." *Supra* n. 12.

care areas" into a rigid standard applicable to each and every hospital.

The Board should decide what areas of a particular hospital are "patient care areas" only on a case-by-case method and only after considering evidence and testimony from the medical staff of the hospital which is charged with the duty of administering the proper therapy to the patients. Only a hospital's medical staff has the expertise to differentiate which areas of a hospital are devoted to patient care and which areas are not.

Although some generalizations can obviously be made as to what areas in a hospital are devoted to patient care (*e.g.*, operating rooms, patient rooms, recovery rooms, etc.), any idea that standard area designations can apply to each and every hospital, whether general care, psychiatric, geriatric, etc., to meet the multitude of potential therapies and treatment is totally unrealistic. Even with similar types of hospitals where identical treatments and therapies are administered to patients who share common ailments, similar hospital areas may carry different designations.

The Board simply is incapable of making rational decisions as to what areas in a hospital constitute "work areas" without the aid of expert medical testimony. Standard rules which classify differing areas of hospitals as "work" or "nonwork areas," regardless of the realities of each situation, and which are based upon nothing more than lay generalizations about hospital activity would be nonsensical in their application, causing tremendous impairment to the patient's well-being. A record as to what constitutes "work areas" must be made. Expert medical testimony must be utilized. Each case must be analyzed separately. Only then can the Board apply its presumptions about the invalidity of employer bans on solicitation

in "nonwork areas" during nonworking time. "Work area" must first be defined.

Any approach to the problem of defining "work area" other than that described above would not adequately protect the patient or hospital visitor. "Whenever in a hospital an emotionally vulnerable group of patients and their visitors may be present, we feel that unique considerations come into play which justify an otherwise overly broad no solicitation rule." *Baylor University Medical Center* v. *NLRB*, 578 F.2d 351, 356 (D.C. Cir. 1978).

> "The question thus presented, to strike an acceptable balance between employee solicitation under the Act projected against the concept of hospital patient care, is indeed difficult. A cautious judgment in such regard must note that error in such judgment may cause irreparable damage to patients, and thus to the public, while error in the other direction can be salvaged by the Board under proper use of its overall expertise in labor matters."[29]

"A patient's attitude toward the hospital and the likelihood of receiving expert care while there depends in part on whether he perceives the staff as concerned exclusively with patient care."[30] "In accommodating the interests of employers and employees in a hospital case the Board must recognize the employer's responsibility for the welfare of patients and other third parties present in the hospital."[31]

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29. *St. John's Hospital and School of Nursing* v. *NLRB*, 557 F.2d 1368, 1371 (10th Cir. 1977).

30. *NLRB* v. *Baptist Hospital, Inc.*, 576 F.2d 107, 110 (6th Cir. 1978). Although these quotes are from cases decided prior to *Beth Israel*, they, nevertheless, show the circuit court's concern with patient care and the difficulties that the courts have met in defining "work areas."

31. *Beth Israel, supra* n. 2, at 395.

IV. Insuring That the Board Utilizes Expert Medical Testimony in a Case-by-Case Approach Does Not Usurp Its Role.

In *Beth Israel*, this Court expressed its reluctance to accept arguments that the Board was not competent to decide whether solicitation or distribution would disrupt patient care. Specifically, this Court evinced its resolve not to allow the institutional role of the Board to be usurped by the health-care community.

> "It is the Board on which Congress conferred the authority to develop and apply fundamental national labor policy. Because it is to the Board that Congress entrusted the task of 'applying the Act's general prohibitory language in the light of the infinite combination of events which might be charged as violative of its terms, *Republic Aviation*, supra, at 798, that body, if it is to accomplish the task that Congress set for it, necessarily must have the authority to formulate rules to fill the interstices of the broad statutory provisions."[32]

Requiring the Board to seek expert testimony from a hospital's medical staff on a case-by-case basis does not encroach upon the Board's institutional role. On the contrary, it enhances the Board's ability to fulfill the duties of that role.

In the health-care field, the industry's ability to produce a quality product directly and immediately affects the safety and well-being of human beings. Adjustments in federal labor policy necessarily affect the industry's ability to protect the patient. This human element compels Board consideration of a non-traditional factor—the industry's absolute obligation to protect the patient. Since only a hospital's medical staff can evalute this factor, it logically follows that the Board cannot fulfill its institutional role without considering the testimony of a hospital's medical experts.

32. *Beth Israel, supra* n. 2, at 385.

V. Alternatively, HCA Stresses That the Situation of the Health-Care Industry Requires This Court to Reconsider and Overrule Beth Israel.

A. The Patient Has a Right to Quality Medical Care

The cases which heretofore have been decided have dealt thoroughly with the traditional *Republic Aviation*[33] considerations—the competing rights of an employer to control his business and of the employees to engage in concerted activity.[34] There is a third consideration which has not been properly addressed. That consideration is the patient's right to quality medical care.

The patient's right to quality medical care is the critical factor which distinguishes the hospital industry from other industries which are subject to the *Republic Aviation* rationale. This right is a vital concern of all Americans. It is more important than the employees' organizational rights. It is more important than employers' proprietary interest in his workplace.

The patient's right to quality medical care has been unwillingly juxtapositioned between the competing and,

33. *Republic Aviation Corp.* v. *NLRB*, 324 U.S. 793 (1945).

34. "Organization rights are granted to workers by the same authority, the National Government, that preserves property rights. Accommodation between the two must be obtained with as little destruction of one as is consistent with the maintenance of the other." *NLRB* v. *Babcock & Wilcox*, 351 U.S. 105, 112 (1956).

oftentimes, colliding interests of the employer and the employees. It is not a competing interest to be added to the *Republic Aviation* balancing test on equal par. It is a right which must remain sacrosanct from and unscathed by the traditional turmoil which results from a labor dispute.

No choice of words more succinctly states the relevant considerations in this case than the following passages from Justice Powell's concurring opinion in *Beth Israel*:

> The rule of *Republic Aviation* was adopted in the context of labor relations in industrial and manufacturing plants, where third parties unconnected with labor or management generally are not involved. In such a setting, it is relatively simple to divide the work environment into the two spheres defined in *Peyton Packing*.
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> The rationality found to exist in *Republic Aviation*, and therefore the validity of the presumption, cannot be transferred automatically to other workplaces, for to do so would sever the connection between the inference and the underlying proof. The Court's approval of the *Republic Aviation* rule was based explicitly on the Board's considered appraisal of "normal conditions about industrial establishments." Conditions in industrial or manufacturing plants differ substantially from conditions in sales and service establishments where employees and members of the public mingle.
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> * * *
>
> In my view, the presence of patients and members of the public in the hospital cafeteria removes the case from the framework established in *Republic Aviation*, just as the presence of customers has that effect in the Board's retail establishment cases. The hospital's function in serving patients, their families, and visitors is much like the retail establishment's function in serving its customers. That a nonprofit hospital does not share the profit motive of a retail establishment does not diminish the hospital employer's professional concern for the welfare of those in its care, including not only patients but also their friends and relatives who come to visit.
>
> It is true that the hospital's primary function is carried out in the immediate patient care areas, just as the retail establishment's main function is carried out on the selling floor. But the Board has applied its retail store rules to public restaurants on the premises of the retail store. See *ante*, p.3, notwithstanding the fact that the primary selling function does not take place there. Public restaurants in retail stores are provided for some of the reasons that hospitals maintain public eating places—including the convenience of the establishment's patrons. In addition, a hospital's more general purpose extends to, and pervades all areas of the hospital to which the public has access; it is not limited narrowly to the provision of technical medical treatment. Part of the hospital's function is to provide a "total environment . . . where the medical needs of patients are served by maintaining a climate free of strife and controversy." *NLRB v. Baptist Hospital, Inc.*, ... F.2d ....., ... (CA6 1978).
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> * * *
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> A presumption developed in and geared to the context of industrial establishments, which the Board has de-

clined to apply to retail stores, simply has no relevance to hospitals.

* * *

[T]he Board's "accommodation" of the competing interest in *St. John's* fails to give appropriate weight to the unique characteristics of a hospital. It amounts to no more than an application of the *Republic Aviation* rule to certain areas of a hospital but not others, despite the fact that members of the public are present and potentially affected even in areas of a hospital not characterized as "strictly patient care" areas.[35]

B. Proposed Rule

HCA submits that *Beth Israel* is inconsistent with the patient's right to quality medical care. The decision's approval of the Board's general approach in the health-care field permits narrow and illogical constructions of "work area." These interpretations stifle a hospital's ability to deliver its essential services. HCA respectfully urges that this Court instruct the Board to readopt the approach that the Board found suitable in *Guyan-Valley Hospital, Inc.*[36]

In *Guyan-Valley*, the Board approved the validity of hospital rules banning solicitation and distribution in areas of hospital to which patients and visitors have access. This approach is the best way to ensure that the patient's right to quality medical care is not jeopardized. Moreover, the Board cannot candidly argue that the approach is

35. *Beth Israel, supra* n. 2, 57 L.Ed.2d at 392-394 (Concurring opinion).

36. 198 NLRB 107 (1972).

totally inconsistent with the purposes of the National Labor Relations Act[37] when it approved and utilized the approach prior to its *St. John's* decision.

As pointed out in Justice Powell's concurring opinion in *Beth Israel*,[38] the Board's approach as adopted in *St. John's* is nothing more than the application of the *Republic Aviation* rationale to selected areas of a hospital. Application of this rationale should be removed from the hospital setting. The presumptions of invalidity which accompany the *Republic Aviation* rationale should similarly be discarded. "Once the Board is deprived of the presumptions of invalidity of an employer's rule, it must establish by substantial evidence on the record as a whole that the employer has violated §§ 8(a) 1 and 8(a) (3)."[39]

CONCLUSION

HCA urges that this Court overrule the narrow application that the Board has given its "general approach." Specifically, this Court should require the Board to approach each contested hospital no-solicitation/distribution rule on a case-by-case basis after proper consideration of the expert testimony of the hospital's medical staff. This case-by-case approach will aid the Board in fulfilling the duties of its institutional role.

Alternatively, HCA urges this Court to direct the Board to reject its general approach altogether and adopt

37. 29 U.S.C. 151 *et seq.*

38. *Beth Israel, supra* n. 2, 57 L.Ed.2d at 392.

39. *Beth Israel, supra* n. 2, 57 L.Ed.2d at 394-395 (Concurring opinion).

the earlier sanctioned guidelines approved in *Guyan-Valley Hospital.*

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